to simple "go home and walk" advice, when supervised exercise training is unavailable or impractical.

The Cost-effectiveness of Supervised Exercise for the Treatment of Intermittent Claudication

Bermingham S.L., Sparrow K., Mullis R., Fox M., Shearman C., Bradbury A., Michaels J. Eur J Vasc Endovasc Surg 2013;46:707-14.

Background: Supervised exercise (SE) is thought to result in improvements in walking distance and quality of life compared with unsupervised exercise (USE) in people with intermittent claudication. However, the cost-effectiveness of SE is unclear. As a result, many patients are currently unable to access supervised programmes.

Methods: We searched MEDLINE, Embase, Cochrane, and Cinahl databases to identify randomised controlled trials comparing USE with SE in adults with intermittent claudication. A Markov model was developed to estimate costs and quality adjusted life years (QALYs) from an NHS and personal social services perspective. Quality of life was obtained from the included clinical trials. Resource use was modelled on current programmes and unit costs were based on published sources.

Results: Depending on estimated rates of compliance, SE was cost-effective in over 75% of model simulations, with an incremental cost-effectiveness ratio of £711 to £1,608 per QALY gained. The model was sensitive to long-term effects of exercise on cardiovascular risk and quality of life.

Conclusions: SE is more cost-effective than USE for the treatment of people with intermittent claudication. Supervised programmes should be made widely available and offered as a first line treatment to people with intermittent claudication.

Vascular Training Profiles across Europe

Avgerinos E.D., on behalf of the European Vascular Surgeons in Training (EVST) Writing Committee Eur J Vasc Endovasc Surg 2013;46:719-26.

Background: The European Vascular Surgeons in Training (EVST) were appointed by the European Society for Vascular Surgery to review the current status and developments regarding training and certification in vascular surgery (VS) across Europe.

Methods: An e-mail-based survey was distributed to EVST representatives in 33 countries. The questionnaire examined the current structure of vascular surgery training and certification (monospecialty, subspecialty, no specialty), as well as the evolving revisions of national curricula. Questionnaires were returned from 31 countries, two of which implement two training models.

Results: Vascular surgery (VS) as a monospecialty is the leading training model in 18 out of 31 countries, nine countries follow the subspecialty model, and six countries have no accredited vascular programs. The mean duration of dedicated VS training in monospecialty is significantly longer compared with subspecialty (3.8 vs 2.9 years, $P = .036$) or no specialty models (3.8 vs 1 years, $P < .001$). 83% of countries implementing an independent certification have recently updated their training curriculum; the respective rates for countries implementing a subspecialty or no specialty model are 56% and 17%. Among countries that offer VS certification, the endovascular logbook is mandatory in 78%, quality control of training centers or trainers is implemented in 62%, and training centers are reported as heterogeneous in 46%. The Working Time Directive is followed by vascular trainees in 10/24 EU countries.

Conclusions: The results of this survey represent the most updated detailed record of the European training profiles in VS and document the diversity of vascular training across Europe.